

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER River City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 921 Nolan St San Antonio, TX 78202	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure the care plan reflected the resident's status for 1 of 3 residents (Resident #1) reviewed for care plan assessments.</p> <p>The facility failed to accurately document Resident #1's care plan dated 2/21/2024 which revealed the resident needed appropriate footwear and was ambulatory and could propel her wheelchair.</p> <p>This deficient practice could place residents at risk of inadequate care.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet revealed resident was a [AGE] year-old female admitted to the facility 01/06/2023 with diagnoses that included: pulmonary embolism (a blood clot that traveled to the lung), stage 3 chronic kidney disease, dementia without behaviors, and protein-calorie malnutrition.</p> <p>During an interview on 4/18/2024 at 3:13:PM with the POA of Resident #1, stated Resident #1 stopped walking in December of 2022 around the week of Christmas.</p> <p>Record review of Resident #1's Annual MDS dated [DATE], the resident had a BIMS (Brief Interview of Mental Status) score of 99(resident was unable to complete the interview), she was coded for upper and lower extremity impairments, and mobility device was coded as a wheelchair.</p> <p>Record review of Resident #1's Care Plan dated 2/21/2024 revealed the resident was at risk for falls with the interventions that included appropriate footwear for locomotion in wheelchair and ambulation in the halls.</p> <p>Record review of Resident #1's Care Plan dated 2/21/2024 revealed the resident was care planned for limited physical mobility with interventions that stated resident was totally dependent on staff for ambulation/locomotion, she was dependent on staff for bed mobility with 2 person assistance; all transfers using a lift.</p> <p>Record review of Resident #1's physician orders revealed the resident was admitted to hospice on 10/28/2023 with the diagnosis of senile degeneration of the brain.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 4/12/2024 at 9:05AM Resident #1 was in bed laying on her right side. The bed was at a safe height and a fall mat was in place adjacent to the bed. She was contracted in fetal position with her knees to her chest.</p> <p>During an interview on 4/12/2024 at 12:24PM the DON stated Resident #1 was not ambulatory, and she was not able to propel her wheelchair. The DON stated the resident was totally dependent on staff for repositioning, feeding, ADLs, and transfers. The DON stated it was important for the Care Plans to be accurate because it provided information on how to care for the residents and the Kardex were provided for the CNAs with the information for them to be able to provide the care needed for the residents.</p> <p>Record review of facility's policy dated Comprehensive Care Planning from Nursing Policy & Procedure Manual (no date) stated: The facility will develop and implement a person centered care plan for each resident, consistent with the resident rights, medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. When developing the comprehensive care plan, the facility staff will at a minimum use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47622</p> <p>Based on observations, interviews, and record review the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the treatment cart for 1 of 1 treatment cart reviewed for drug storage.</p> <p>The facility failed to ensure staff locked the treatment cart when it was left unattended.</p> <p>Findings included:</p> <p>During an observation and interview on 4/11/2024 at 10:20AM the nurse treatment cart was unlocked and there was no nurse in the area. The Administrator approached the unit and stated the nurse was not on the unit and he locked the cart.</p> <p>This failure could result in harm due to unauthorized access to medications, misappropriation, and drug diversion.</p> <p>During an interview on 4/11/2024 at 1:30PM Nurse A stated she did Resident #1's wound care, cleaned the cart and she thought she locked it. Nurse A stated she would accept the responsibility for not locking the treatment cart and stated it was important to lock the treatment cart because medications and scissors were stored in the cart and if someone gets in the cart, it could cause harm by swallowing the medication or cutting themselves with the scissors. Nurse A stated it can also be contaminated if someone gets into the cart. She stated she had training for locking the medication cart and the treatment cart and the importance of locking them when they are not being used.</p> <p>During an interview with DON on 4/1/22024 at 12:24PM she stated it was important to ensure the cart was locked because it contained medications and scissors that residents could access and it should be locked for safety.</p> <p>Record review of facility policy titled, Medication Carts from Pharmacy Policy & Procedure Manual 2023 stated in part; 2. The carts are to be locked when not in use or under the direct supervision of the designated nurse and 3. Carts must be secured.</p>		